University of Alberta

Boundaries and Trust in Community Mental Health Nursing

by

Terri Lynn Lidstone

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

Faculty of Nursing

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Boundaries and Trust in Community Mental Health Nursing** submitted by **Terri Lynn Lidstone** in partial fulfillment of the requirements for the degree of **Master of Nursing**.

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Abstract

Mental health nurses often care for their clients in unorthodox ways as to standards of practice of various Canadian nursing associations. The methods they use in providing care sometimes fall into an area known as the "gray zone" of nurse-client boundaries. Practices included in this zone, including gift-giving and self-disclosure, can be viewed either as appropriate or as boundary violations, depending on whether or not they were therapeutic in the nurse's judgment. Such practices can help build trust and strengthen the relationships that community mental health nurses have with their chronically mentally ill clients.

This research study explores the process of boundary setting and revision undergone by nurses working with chronically, severely mentally ill individuals in a unique community mental health setting. The data yielded a core variable of trust which influenced all aspects of the care given to these clients. An explanatory process, called Therapeutic Negotiation which illustrates the three phases of the nurse-client relationship and the goals of each phase was developed from this research. This process and the resulting explanations given will aid nurses in better understanding the concept of and the reasons for crossing boundaries as well as the importance of understanding the justifications for unorthodox nursing practices. This may lead in turn to more effective care of a unique and often challenging type of client.

Dedication

This thesis is dedicated to the extraordinary caregivers who work with the chronically mentally ill. The creativity and caring they possess is inspiring.

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I would like to acknowledge those individuals who assisted me in completing this research. I am grateful for the guidance and encouragement I received from Dr. Olive Yonge, my supervisor. She gave generously of herself in helping me to complete this thesis. Her positive demeanor and unfailing support were instrumental in getting me to this point.

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I. Introduction

Research on professional boundaries has been largely neglected by the nursing profession. While the Alberta Association of Registered Nurses (AARN) has developed a document on this issue, much of its content is limited in its scope (1997). In a clinical setting such as community mental health, much of what nurses do falls within a 'gray area' of what the AARN considers boundary crossing practices. Accordingly it is important to understand the process and reasoning nurses in this setting use to establish, change or stretch boundaries with their clients in order to develop better guidelines and improve nurses' education on boundary issues. This study aims to advance knowledge and influence practice regarding nursing interventions in the community mental health setting.

Purpose of the Study

This study was undertaken to illuminate an under-researched area of nursing practice. Its purpose is to explicate the process nurses undergo in establishing, maintaining and changing boundaries with clients in a community mental health setting. Results could influence policy of professional nursing organizations, improve understanding of concepts relating to boundaries, and impact both educational and clinical settings.

Research Questions

This study is guided by these questions:

1. What is the process by which boundaries in relationships between community mental health nurses and their clients are (a) established;

(b) maintained;

(c) changed

2. What is the reasoning behind the flexibility of nurse-client boundaries in this setting?

Organization of the Thesis

This thesis is organized into five chapters. Chapter One states the problem and the purpose of the study and details the research questions. Chapter Two reviews relevant literature on boundaries and the researcher's assumptions. Chapter Three covers the research method used, data analysis and ethical considerations. Chapter Four introduces the findings. Finally, Chapter Five discusses the findings of the study in light of relevant literature and concludes with their implications and recommendations for further research.

II. Review of the Literature

In grounded theory research, the primary purpose of reviewing the literature is to stimulate thinking by focusing the researcher on significant concepts. As well, it can identify gaps in the literature and concepts and relationships which have already been explored (Strauss & Corbin, 1990). A literature review was conducted to explore the area of boundaries within the nursing profession. Since little literature exists regarding professional boundaries in the nurse-client relationship, this review explores policies of Canadian nurses' professional associations regarding boundaries, the gray zones often faced by nurses, the nature of nurse-client relationships, and the uniqueness of community mental health nursing of adults.

Professional Nursing Associations

The Alberta Association of Registered Nurses (AARN) describes professional boundaries as, "...those lines which separate therapeutic behavior of the registered nurse which, whether well intentioned or not, could detract from achievable health outcomes" (1997, p. 5) and requires all nurse-client contacts to be therapeutic in nature, even when they appear to be social. Various Canadian Nursing Associations support this definition of professional boundaries (Registered Psychiatric Nurses Association of Saskatchewan, 1993; Registered Psychiatric Nurses Association of British Columbia, 1995; Registered Nurses Association of British Columbia, 1995; Nurses Association of New Brunswick, 1995). Pilette, Berck, & Achber (1995) state that professional boundaries provide

security by setting limits but are complex and at times unclear, thus the therapeutic relationship depends on knowing the delicate balance between actions which are helpful and those which are not.

The AARN (1997) accepts the occurrence of deviations from established boundaries for therapeutic purpose where the professional has a clear understanding of the complexities of professional boundaries. These deviations are described as gray zones and often come into play when nurses decide that stretching or crossing a boundary meets an individual client's needs. The Nurses Association of New Brunswick (1995) further suggests that behaviours acceptable in some circumstances may constitute boundary violations in others. In such cases it is the nurse's role to make a professional judgment in relation to the behaviour within the context of the client's therapeutic needs.

The Nurse-Patient Relationship

A therapeutic nurse-client relationship is described by the AARN (1997) as a relationship established and maintained through the provision of care which contributes to the client's health outcomes and is related to the nurse's knowledge, skills and attitude. McAliley, Lambert, Ashenberg & Dull (1996) describe a therapeutic relationship as being characterized by empathy and trust and believe that it facilitates the achievement of patient-oriented goals. McAlily et al. (1996) have developed a decision-making framework to assist caregivers in viewing certain practices comprehensively, intending it to foster a deliberate, positive approach to nurse-client interactions and provide a guide for retrospective analysis of troubled relationships.

Two studies relating to professional boundaries come from the area of pediatric nursing. Rushton, Armstrong & Enhill (1996) discuss the difficulties pediatric nurses often have in maintaining an advocacy role with clients and their families, suggesting that nurses are encouraged to stay within the boundaries of a therapeutic relationship with no guidance to help them do so. While establishing professional boundaries within the nurse-patient relationship is essential for a safe connection between the nurse and the client, alterations of these boundaries can lead to ambiguity within the nurse-client relationship and even sub-optimal nursing care. Rushton et al. assert that nurses are at risk for boundary violations without conscious attention to maintenance of therapeutic professional boundaries. A phenomenological study done by Totka (1996) regarding professional boundaries within pediatric nursing corresponds with this view. Totka states that the lack of discussion and charting related to the connections and relationships nurses often have with their clients make it not surprising that issues of boundary violations are problematic and suggests that nurses begin to dialogue about their experiences with boundary issues, both positive and negative.

Nursing theorist Hildegarde Peplau's Conceptual Frame of Reference for Psychodynamic Nursing suggests that the therapeutic nurse-client relationship reflects the essence of nursing (Peplau, 1952). Peplau identified 3 stages through which the nurse and client move together: orientation, working, and resolution. The relationship between the nurse and client whilst moving through these stages is dynamic and unique and both participants influence the relationship.

Forchuck (1995) uses Peplau's theory as a conceptual base for her secondary analysis of research data collected to examine the initial phase of the nurse-client

relationship, the results of which indicate that the combination of nurse-client factors is more predictive of the quality of the relationship than assessing either the nurse or the client independently. Forchuk concludes that therapeutic relationships are extremely complex in nature and, although individuals bring personal characteristics into the nurse-client dyad, the combination of the individuals creates the unique situation.

A study of nurses' perceptions of the psychiatric nurse-client relationship by Heifner (1993) focuses on the concept of positive connectedness. Heifner defines positive connectedness within the psychiatric nurse-client relationship as, " a therapeutic state of interaction that enhances the effectiveness of the relationship and benefits both the nurse and the client" (1993, pg. 14). Mutual connectedness between the nurse and the client occurs when the union between them is based on familiarity with one another, nursing care, and client trust. The findings of Heifner's exploratory descriptive study suggest that this connectedness enhances the therapeutic relationship and benefits both the nurse and the client. She suggests that reciprocation, mutual investment, and risk-taking which result in mutual trust are positively related to the development of connectedness in the psychiatric nurse-client relationship. In attempting to achieve positive connectedness it seems probable that boundaries between the nurse and the client may be stretched.

Janice Morse's (1990) grounded theory study regarding the establishment of commitment and involvement in the nurse-client relationship supports Heifner's ideas regarding nurse-client connectedness. Her findings indicate that in a connected relationship the client is seen by the nurse first as an individual and then as a client. This connectedness can evolve from the client's needs or from a prolonged relationship, such as

one would find in community mental health nursing. The client will choose to trust the nurse and in return the nurse will often bend or break rules.

A concept analysis by Marck (1995) regarding therapeutic reciprocity further addresses the issue of connectedness, finding that a theme of mutual exchange occurs from various perspectives of the concept of therapeutic reciprocity. This exchange may involve gift giving, mutual accommodation of personal space, mutual self-disclosure, exchange of humor, and client participation in decision-making. In regard to disclosure in particular, Marck states that trust and empathy are promoted when personal thoughts or feelings are disclosed appropriately between the nurse and the client.

Community Mental Health Nursing

In community mental health nursing the relationship between the nurse and client is of utmost importance. Mental illness affects an individual's personality and consequently often influences the relationships which they establish (Yuen, 1985). Overall, mental illness impairs ability to communicate and form meaningful relationships and can lead to isolation, which the nurse-client relationship must break. Interaction between nurse and client which encourages flexibility, freedom of expression and spontaneous disclosure can be a powerful therapeutic tool.

Community mental health nursing focuses on assisting the patient to function as well as possible in the community setting. The goal is social adjustment rather than alteration of personality. Of paramount importance is the concept of continuity of care which allows for holistic care and lessens the chance of fragmentation and potential client

drop-out (Miller, 1981). Individuals with chronic mental illness require long term support. Intervention focuses on increasing the client's resources, minimizing all types of stressors, and teaching coping strategies (Richie & Lusky, 1987). Such relationships often last for years and are built on trust and reciprocity. In their evaluative study of a community mental health program, Forchuck & Voorberg (1991) emphasize the necessity of consistent, longterm relationships between community mental health nurses and their clients, as well as role flexibility on the part of the nurse.

A gray zone community mental health nurses often enter regards gift-giving. Vegetables, clothing or old appliances are often given to needy clients. Within the policies and discussion papers of Canadian professional nursing associations, little is written about this practice except to say it is discouraged. However, Yonge & Molzahn (1996), in their grounded theory study of nontraditional caring practices of nurses found that many nurses go beyond traditional practices within their patient care and give gifts, both material and immaterial, to their clients. While the authors describe these practices as nontraditional exceptional caring, they could also be considered to fit into the gray zone which is described by the AARN.

Most of the emphasis is on the acceptance of gifts by the nurse, which professional associations state is undesirable, though they outline factors influencing a nurses decision to accept a gift from a client (Nurses Association of New Brunswick, 1995, Registered Nurses Association of British Columbia, 1995). In a study that explores gift-giving from the perspective of caregiver as recipient, Morse (1991) asserts that the process of gift-giving reflects the nurse-client relationship, that the gift itself is a symbol of the

relationship, and that taboos regarding gift-giving should be removed to benefit both the patient and the nurse.

Much of what the nurses do in community mental health settings appears to stretch boundaries. Nursing care focuses on helping clients to cope with day to day life with a minimum of stressors, which nurses are instrumental in decreasing. This may involve grocery shopping with clients, assistance in housecleaning, taking clients for coffee, or even bringing gifts from home. It could be assumed that some of these relationships have become personal and are no longer therapeutic, but the profession must understand how nurses themselves to the point of exceeding conventional limits or boundaries of care.

A study of community health nursing by Kristjanson & Chalmers (1990) found that the approach taken by nurses in home visits varied. In some cases, the reasons for the visit were clearly stated and the visit itself was conducted in a business-like manner. In other cases, the purpose of the visit was outlined vaguely or not at all and the visit itself appeared to blend social and professional discussion. In community mental health work, the latter is often the case. Clients are often isolated and the nurse may be the sole human contact they have. For this reason, nurses may attempt to build trust in relationships by allowing interactions to take on a somewhat social perspective. According to community mental health nurse S. Best, "this relationship is often the only tool you have with these clients. The more trust that the client has in you and in the relationship you share, the more likely they are to be compliant with medications or hospitalization" (personal communication, November 4, 1996).

While the literature describes therapeutic relationships and boundaries as well as boundary violations, it does not describe the process nurses undergo when facing potential

boundary crossings, which must be taken in the context of individual situations and analyzed for descriptive themes to be understood. This endeavour is worthwhile, however, as it can open minds to practices often seen as contrary to the policies of professional associations, and because much insight can be gained into the teaching of professional boundaries to practicing nurses and nursing students.

Assumptions

The researcher enters into this study with some assumptions which influence the course of the research. The first is that the nurses interviewed will have at some point in their careers encountered or even crossed a boundary and practiced within a gray zone. The second is that the level of education of these nurses will not influence their boundary crossing behaviour, while the degree of experience and mentoring these nurses received will. The third is that the nurses interviewed will have a minimum of 5-10 years nursing experience, an assumption based on knowledge that they have all come from an inpatient psychiatric setting originally and that their entrance into a community mental health setting was based on seniority. Finally, the researcher assumes that the participants in this study will be articulate and insightful enough to discuss the reasoning behind crossing boundaries with their clients.

III. Method

Little is known of the process of establishing, maintaining and changing boundaries within nurse-patient relationships, therefore grounded theory is the method used to investigate this topic. This method is based on symbolic interactionism and was first developed by Glaser and Strauss to address issues of human behaviour (Glaser & Strauss, 1967). The primary purpose of grounded theory is to generate explanatory models of human behaviour which are grounded in the data (Morse & Field, 1995). Grounded theory relies on inductive reasoning based on data collection and analysis, thus precluding the researcher from imposing preconceived ideas and theory relating to the phenomenon of interest (Glaser & Strauss, 1967). The purpose of this research is to explore the process of establishing, maintaining and/or changing professional boundaries and, in doing so, develop a beginning theory explaining this process, which is congruent with the grounded theory approach of discovering the basic social psychological processes as the subjects experience them (Glaser & Strauss, 1967).

Sampling

Purposive and theoretical sampling was undertaken for this study. Theoretical sampling is considered essential for the inductive-deductive process which defines grounded theory. Inductively, the theory emerges from the data collected and, deductively, theoretical selection of participants leads to testing the emerging theory (Morse, 1991). Initially participants were chosen purposively for their broad knowledge

and experience in the area of community mental health nursing. Throughout data collection and analysis further participants were interviewed based on the theoretical needs of the study.

The participants for the study were community mental health nurses able to speak and understand English, and to articulate their thoughts, feelings and experiences. The need for participants was advertised by putting information sheets in nurses' mailboxes and word-of-mouth (Appendix B). The number of participants needed was determined by the researcher's satisfaction that a conceptual framework was developed which adequately answered the research questions. Six took part in the study, which the researcher decided was adequate to achieve saturation of the data based on the fact that no new information was elicited.

Data Collection

Data were collected through in-depth interviews with the study participants and were analyzed concurrently with collection to identify and clarify emerging patterns and processes. As patterns began to emerge within the data collected, interview questions were developed to test and clarify identified concepts.

The participants were interviewed up to one hour at a time and up to three hours total, with approximately a one to two week time period between interviews. The interviews took place at a convenient location and time for the participants and the interviews were scheduled on an individual basis, allowing enough time in between interviews for data coding and analysis. Initially, the participants were asked open-ended

questions such as those included in the question guide (Appendix A). As data were collected and analyzed, a more structured approach was taken in order to focus on areas which the analysis suggests need more clarity or exploration. As the interviews progressed, the questions asked were dependent on the responses received from the participant. All interviews were tape-recorded and transcribed verbatim. Following each interview, field notes were written immediately to supplement the taped interview including details and descriptions in the context of the interview, the nonverbal communication and the physical setting, information which became part of the data collection and provided contextual data during analysis (Field & Morse, 1995).

Theoretical memoing was also done as data was collected and analyzed. Memos were written which recorded the researcher's thoughts and ideas about the relationships emerging from the data (Morse & Field, 1995). These notes are a written record of ongoing analysis relating to the formulation theory (Strauss & Corbin, 1990). A personal journal was also kept, recording the researcher's thoughts and feelings throughout the research process. Self-reflection assisted identification of personal values and beliefs and recognition of personal bias. All data were handled in a consistent and organized manner. Interviews were transcribed immediately following the interviews and were reviewed by the researcher to ensure accuracy.

Data Analysis

Initially, first-level coding occurred. This entailed line by line analysis with descriptive codes being assigned in the margin of the data file (Morse & Field, 1995). These open codes were then grouped according to similarities and differences into clusters called subcategories which identify relationship links between categories. During this stage of axial coding, connections were made between categories and their subcategories. The focus was on specifying a category in terms of the conditions which give rise to it (Strauss & Corbin, 1990).

Following axial coding, selective coding occurred. This is a process of categorizing the concepts and relationships identified previously (Morse & Field, 1995). Theoretical explanations were sought through further analysis of documentation and coding. Theoretical coding refers to this process and requires examining the data in a theoretical way rather than descriptively (Baker, Wuest & Stern, 1992). One core variable was developed to which all other categories relate. A story line was written in order to achieve integration of a central or core category. Validation of the theory was done with the data and thus is grounded in the data.

Rigor

Issues of personal bias must be addressed. As a mental health nurse, the researcher must ensure that personal assumptions and bias do not interfere with the data collection and analysis. This researcher kept an ongoing journal of personal assumptions

and beliefs so that they could be acknowledged and controlled as much as possible. Regular meetings and e-mail correspondence with the researcher's thesis supervisor regarding data collection and analysis was undertaken in order to ensure that procedure and techniques were properly followed.

It is important in a study such as this to leave a detailed audit trail clearly documenting the researcher's decision-making process. This ensures, among other things, that the researcher is alert to subjective interpretation and personal bias. Documentation is critical in ensuring a rigorous qualitative study. Field notes and memos comprise this trail which documents the researcher's insights and decisions (Field & Morse, 1995). In this study the researcher descriptively recorded notes which were be synchronized with other data and used the constant comparison method during data collection and analysis to ensure that the data was congruent with the experiences of the participants.

Since the research may lead to admissions of exceptions to the AARN Standards of Practice, the researcher attempted to establish a rapport with the participants to ensure they felt comfortable in telling the truth. According to Morse & Field, "qualitative researchers try to increase trustworthiness by prolonged contact with the informants or by using long periods of observation" (1995, p. 144). More than one interview per participant was necessary to build this relationship.

Credibility of informants was ensured through selection of participants with experiences of the phenomena of interest. Interviewing continued until the data became repetitious or saturated, ensuring that the study met the criteria of adequacy. As expected, all of the participants had a minimum of ten years of experience in the field of mental health nursing and had dealt with boundary issues at some point in their careers.

Credibility was further ensured by keeping interview questions open-ended, asking the participants to explain their own definitions of boundaries and encouraging participants to relate anecdotally their own experiences of boundary issues.

Ethical Considerations

Consent was obtained from participants on a voluntary basis. Information forms were provided to all nurses working this particular community mental health setting (Appendix B) who had the opportunity to read the form and then decide if they wished to participate. Those who chose to participate contacted the researcher at a telephone number listed on the information sheet, at which point the researcher set up a place and time convenient to the potential participant to meet and discuss the study in further detail. At the initial meeting, the study was explained and the consent form given to the potential participant (Appendix C).

The agency in which the study took place was asked for permission to conduct the study. No risks to participants were anticipated. Participants were made aware that at any time during the study they may drop out and/or refuse to answer specific questions.

In a study such as this, where actual quotations of the participants will be used, confidentiality cannot be maintained (Morse & Field, 1995). The participants described specific experiences with clients which, when quoted within the study, could potentially identify them. The researcher ensured that all participants were aware of this both through discussion and on the consent form. Furthermore, the researcher attempted to omit from quotes particularly identifying data as well as identifying characteristics of the participants.

Anonymity was maintained. All names from quotations as well as other identifiers which may link data to individual participants was removed (Morse & Field, 1995). Pseudonyms were used for all participants. Demographic data was not broken down into specific age groups, years of nursing, ethnicity, etc. No identifiers such as age or gender were used following quotes.

Participants were informed that all tapes would be kept in a locked file cabinet and that all identifying information would be erased from these tapes. All transcripts were coded and participants identified by a code number. The informed consent forms are kept separate from the data in a locked file cabinet and the lists containing the participants' names and their code numbers are stored separately. Transcripts from this study will be retained for seven years and the actual tapes will be erased following completion of the study.

IV. Findings

This chapter presents the findings in a narrative style and concludes with a storyline which is a compilation of the participants' experiences. The categories that emerged from the analysis process are explicated with participants' quotations illustrating the associated concepts. Each phase of the process of establishing, maintaining and changing boundaries in the nurse-patient relationship is discussed in the context of chronic mental illness. The relationship to the core variable, *trust,* is demonstrated for each phase of the process.

Context

As outlined previously, the clients referred to in this study are individuals experiencing chronic mental illness. While the severity of illness varies from person to person, the impact of the illness on their lives is uniformly tremendous. Part of an assertive outreach program, the care they receive is consistent and ongoing. Relationships between nurses and clients often last for many years with these nurses endeavouring to develop and maintain effective, trusting relationships with their clients in order to minimize the stressors in their lives. According to Repper, Ford and Cooke (1994), caregivers in this setting must adopt both a client-centered and flexible approach to care. Clients value flexibility, feeling it gives them some control. Sheryl describes how mental health nursing in the community differs from that in the hospital setting:

> It's the length of the relationship, it's the depth of the relationship because you do become much more involved with their everyday life than you do in a hospital setting. It's knowing the family members and knowing their view of the clients role within that family and often times you're involved in family squabbles that you play referee, which you just don't get in the hospital setting. It's vastly different that way and because you are there with the intention of a life time commitment then you do become more involved.

The subjects in this study identified several concepts relating to chronic mental illness including: stigma, loss, abandonment, and isolation. They also identified the cyclical nature of mental illness. Each respondent suggested that trust, consistency and flexibility are of paramount importance to the development of effective therapeutic relationships with their clients.

The concept of the stigma of mental illness was central to the discussion with the respondents. Their clients indicated that they felt the negative public perception of their illness. They saw themselves as different and many felt that they could not function effectively in the public domain. Susan expressed her thoughts about the stigma surrounding mental illness this way:

> The mental illness affects the everyday part of their lives. I mean it may affect their ability to communicate, it may affect the way they look or dress. It may cause them to do inappropriate things so those are the things that people see and those first impressions last in people's minds and they never get beyond those initial things.

Dina suggests that the stigma is compounded by a chronic physical state, with deficits in basic hygiene and self-care:

> When we say sit on the bus and somebody sits down beside us that smells of b.o. (body odour) and there are coffee stains down their front, fingernails are grubby, poor quality clothing on, their hair is all messed up. I mean, how do you react? Don't you kind of just pull away?

Loss and abandonment are familiar to people with chronic mental illness. Loss involves all aspect of their lives: friends, family, belongings, sense of accomplishment, decision-making abilities, and hope. Abandonment or even the expectation of rejection is often a fear when establishing new relationships with other individuals, including caregivers. Many have been abandoned by friends and family at points throughout their lives, so further abandonment can be a real fear. According to Susan, loss and abandonment are overwhelmingly present in this population:

> ...they would be in hospital twice a year and each time they would end up being kicked out so essentially when they came out each time, they started over again, never going back to anything familiar, never going back to anything the same, so when you look at it in terms of losses it is tremendous. They have nothing in their life, nothing in the sense of even possessions, but nothing in the same sense that there is no home. What is home?

Dina suggests that abandonment by families is not uncommon :

> Often times they are alone and often they have, families have just divorced themselves from the patient simply because of the tremendous difficulty,

guilt and misunderstandings and behaviours that make the families somewhat afraid.

Just as loss and abandonment pervade this population, so does isolation. For various reasons, this appears to be brought on by a disconnectedness with others. Susan suggests that the illness itself, the fear and the psychosis can be responsible for isolation:

> I think for a lot of people they just kind of disappear and they are never seen or heard from again until they decompensate and then behaviour brings them into public attention. But they spend days kind of holed up in an apartment somewhere being afraid to go out and psychotic and never really knowing that until finally they lose it.

One other aspect of chronic mental illness that several of the nurses interviewed described is the cyclical nature of the illness. They suggested that the role they played was not to stop decompensations or to affect the cycles of the illness but to increase the wellness time. When the clients did inevitably decompensate, the role of the nurse was to identify that process early, treat it promptly and hopefully avoid a lengthy and disruptive hospitalization.

One final point regarding the context of the care given is a crucial issue mentioned by each and every respondent. All nurses stated in some way that their guiding philosophy of care includes the belief that each person with a mental illness is a person first. All believed that respecting clients and viewing them as individuals was of primary importance in this and all of their professional relationships. When asked about the principles which guide her interactions, Sarah stated:

> I think the principles are so simple in that they are just basic human principles of dignity and respect and common courtesy and all the things you would like other people to do, as you do unto them. And then on top of that there is this illness, but what gets the most focus is the person. I mean you can't have an illness unless you have a person but often we see the illness without the person.

The informants in this study described their own experiences of going beyond the traditional role of nurses in this unique setting. Sarah acknowledged that with each client a process begins which is cyclical in nature and continues throughout the relationship. Through such accounts, the author identified a process of 'therapeutic negotiation'; a cyclical process, mimicking the patterns of wellness and decompensation evident in individuals' experiencing chronic mental illness (see Figure 1). Each subject was quick to point out that the practice of going beyond was not undertaken lightly. It occurred after careful assessment and consideration and ultimately was used to reach a goal to benefit the client.

The negotiation involves changing boundaries within the nurse-client relationship. Its goal is the development of trust. The relationship is broken down into three steps or phases: establishing the relationship, evolution of the relationship, and crisis. These may not appear in linear order, however. Typically, the crisis phase leads back to phase II, evolution of the relationship. Although boundaries remain fluid throughout this process, the fluidity of different stages may vary. During the initial phase of establishing the relationship, they tend to be more rigid as the nurse and client get to know one another.

Evident in this process is the core variable of trust. Trust is a commonality of all three phases as well as an ultimate goal of the developing relationship.

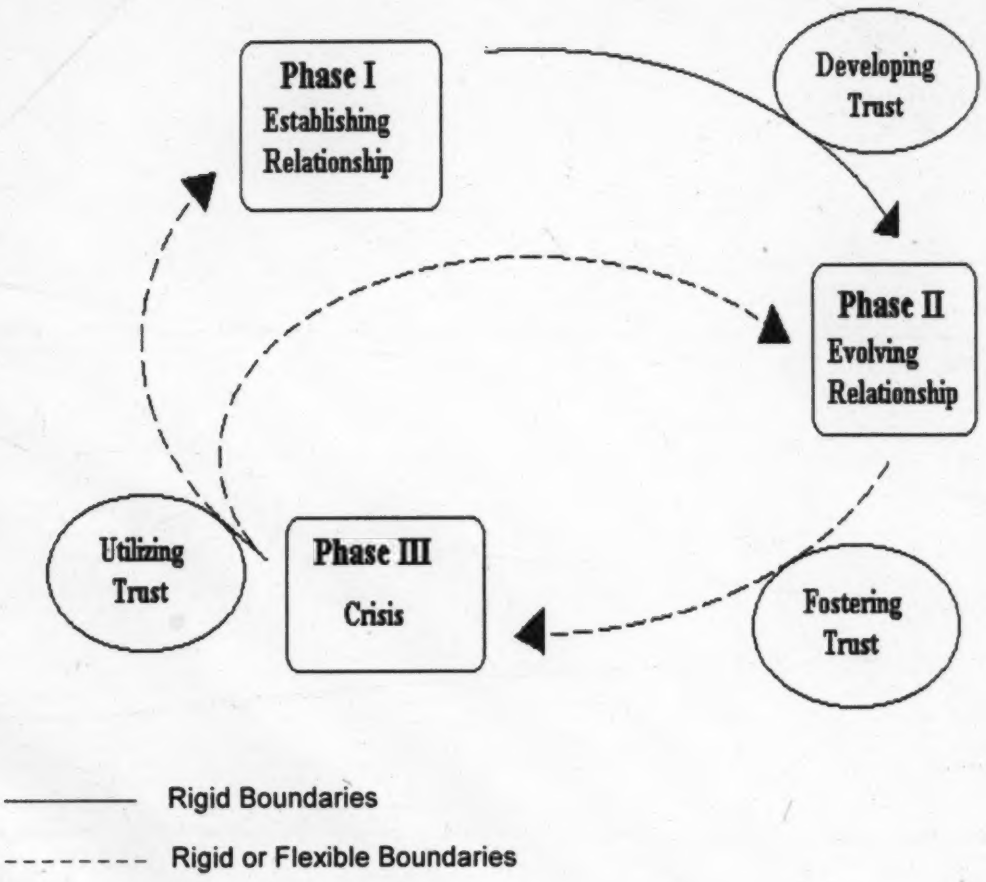

Figure 1. The Process of Therapeutic Negotiation

Phase I: Establishing the Relationship

Initial meetings with clients set the stage for future involvement. Roles and expectations are explored and discussed and the relationship begins to take shape. The main goal of this phase is to establish trust between the caregiver and the client. Because the relationship is anticipated to be long-term, trust builds slowly over time with each interaction contributing to the relationship's strength.

Interacting.

Interactions between nurses and clients in this beginning phase are used to strengthen the mutual relationship. As trust has not yet been built, this is a time when interactions are geared toward its development. These include protecting, assessing, socializing, involving, limiting and negotiating with the client, and are based on the basic tenets of respect. Examples of building trust within the relationship identified by the participants include being on time to appointments, calling clients if late or unable to make it, and being available within the limits set during the first meeting. Lynn described the trust she develops with clients as evolving over time:

> It evolves and I think it's kind of the way we work. They can tell if you are genuine or not and I think that's a big part of establishing trust with these people. If you come up to them and just treat them as people that have illness but not have an illness first, you get trust that way. You have to be reliable, if you say you're going to show , you must show up at the time you said. They must perceive that you are going to bat for them.

These initial meetings assure the clients, who may be paranoid and fearful of close relationships, that their caregivers can be trusted, will treat them with respect and

undertake to assist them in staying as well as possible. During this phase assessment is emphasized. Caregivers constantly evaluate how clients cope with everyday skills such as shopping and banking and monitor symptoms and medication compliance. In this early phase clients and caregivers are learning about one another and how best to respond and interact.

Impacting.

Even in this early phase of the relationship, caregivers can have an impact on the quality of life and connectedness of those they care for. Most participants acknowledged that their clients are often completely alone in the world with little or no contact with others. Once the nurse enters their lives they often can establish a sense of connectedness. This can prove difficult, however, as some may feel threatened by the potential closeness and may try to maintain more distance. Sheryl illustrates this phenomenon this way:

> Often times the individual hasn't had very many long lasting relationships in their lives and they really don't know or understand how to continue a long lasting relationship. Sometimes you'll just get started with a client and believe that your relationship is going very well and all of a sudden that individual will pull back out of fear, out of lack of commitment. Who knows? There are various reasons.

This "pulling back" is a factor in developing trust with clients who have little experience with trusting, caring relationships and may be somewhat suspicious. Trust may take longer to build with some. For this reason caregivers in this phase focus their energy on working with their clients, developing caring relationships, being respectful and ultimately building lasting rapport with which trust grows. In this context caregivers can

enhance their clients' quality of life. The participants discussed the importance of simple personal contact in this respect, among all other tasks and roles which caregivers take on. It is vital for some clients to have someone to listen to them, to discuss their hallucinations or fears with. For others, it is assistance with filling out forms, doing banking and planning grocery lists which is invaluable. Sarah emphasizes the influence caregivers have upon their clients' quality of life even on basic issues such as housing, which they may lose during hospitalizations forcing them to move from place to place:

> The fact that you can maintain somebody in one place that they are happy with for four or five years certainly adds quality to their life. It adds quality to their life, I don't know if that is rehabilitation but it's certainly progress.

In this embryonic, first phase of the nurse-client relationship, caregivers have the ability to impact their clients' illnesses. Through careful monitoring and assessment, they can establish whether or not the client is compliant with their medication, assess the severity of current symptoms, and monitor for early decompensation. While the trust may not be established well enough at this point for patients to surrender decision-making, this may change at a later stage. Meanwhile, they can work together on increasing medication compliance, assessing the need for further visits to the physician, as well as an appropriate visitation frequency. The goal in such situations is to attempt to decrease the severity and length of a decompensation and get the patient back on track with minimum disruption. While this may become easier as the relationship develops, the respondents in this study believe that even initial involvement in their clients' lives positively affects their wellness.

Going Beyond.

Common amongst the participants was a belief that in the initial phase of the relationship boundaries should be rigid and established from the outset. Clients and caregivers are learning about one another and a degree of trust has not yet been established so it is unlikely that the caregivers will go beyond the boundaries identified with the client during the initial meetings. Although boundaries tend to be rigid in all instances at this phase of the relationship, the assessment which occurs here guides decision-making on future practice. Knowledge of their clients' behaviours and needs tells caregivers whether boundaries should loosen or a more formal, structured relationship should be maintained. Sarah relies on knowledge of clients' regular habits to decide how far she will go to help out the client once the relationship has evolved and trust is established. Knowing a client is generally very conscientious and responsible with finances influences her reaction if a client runs out of money for food during a crisis: "If I know this behaviour is out of the ordinary then I may decide to take some food to that person to keep them going until their next cheque". She also emphasizes the importance of knowing her clients' normal patterns so that when something unusual happens she may decide to go beyond what is considered normal duty.

Another factor that appears to play a role in that decision to go beyond rigid boundaries is the client's diagnosis. Interestingly, most participants suggested that when taking on a new client diagnosed with a Personality Disorder, they tend to keep the boundaries rigid throughout the relationship. Lynn who has experienced working with such individuals states:

> I find from my experience that a whole lot of Personality Disordered people don't have boundaries. The are quite adept at bringing things out of people and that is part of their way of surviving. They are good at kind of drawing things out of you and trying to go beyond boundaries. It has to be the other way around, you have to build strong boundaries for them.

The above example illustrates the need of keeping the boundaries rigid during the initial phase of assessment and learning about the individual to whom care is given. Based on the interactions and boundaries set up within the relationship, trust begins to develop and strengthen as the relationship enters phase II.

Phase II: The Evolving Relationship

The evolving relationship is the second phase experienced by the participants in the process of therapeutic negotiation. During this phase of the relationship, trust between the client and the nurse has developed and the goal is to continue to foster that trust. The time the participants identified as required in moving from phase I to phase II varies. Some clients take months or years to reach this point, while others do it more readily. Some vacillate between phases I and II.

Interacting.

Interactions at this point are much the same as in phase I. Assessment is ongoing and nurses and clients deal together with everyday issues. Trust is fostered by caregivers showing ongoing respect and advocating for clients, involving clients in decision-making and being available to clients within the limits already established

Impacting.

As with interacting, impacting remains similar to phase I of the process. Relationships nurses have developed with their clients continue to positively influence their quality of life, connectedness and their illnesses. Some of the participants describe difficulties with patient closeness at this point in the relationship. As trust develops patients sometimes view their nurses more as friends than caregivers. Sheryl relates:

> Initially of course it is purely professional but once the relationship has developed nine out of ten of them call you their friend. You are not a nurse anymore you know you become a part of the parcel of their life.

Other participants echo this observation but don't attribute difficulties to it right away. However, if it is not dealt with it can become more of an issue when the nurses attempt to exert some control over decompensating clients. Generally, participants found this difficulty easily dealt with through reminding clients that they are there as nurses and, while they may also be friends, the primary role is as caregivers. Susan acknowledges the impact that the distinction between friend and professional can have on her:

> I have two or three people on my caseload that if they weren't, if we hadn't met in the context of nurse-client, they are people I would like and could be friends with. That doesn't happen often but it does happen. I have one lady on my caseload right now, a very just a lovely person. She is an artist and I really like her as a person. I have known her now for about 6 years and I see her weekly so you can imagine that boundary issues have come up for me.

Going Beyond.

It is in this second phase of the process of therapeutic negotiation that nurses may begin to loosen up boundaries. Again it is important to note that this does not necessarily occur with each client. It is a choice based on knowledge of clients and their needs. One participant felt it was important not to overdo 'going beyond' behaviours, that while more can be given to clients as needed, it is extremely difficult to remove or reduce a practice once it has begun. Often when a unique situation has arisen where a nurse gives extra to a client, discussion or debriefing ensues which includes the nurse's rationale for the practice and, if it was a unique occurrence, reestablishes the original boundaries through discussion and limit-setting.

Each nurse in the study described instances of going beyond what usually would be considered acceptable practice. Most identified their rationale for going beyond as being the development of trust. For instance, Susan described self-disclosure of her personal life, of happy rather than burdensome news such as one would share with acquaintances and friends. Her rationale for sharing this with her patients was reciprocity. Patients were expected to open up to her, to share their lives with her, yet she was expected to allow them to know only her professional persona. A more effective way of communicating with them, she felt, was to give back a little, to share a bit of herself in order to appear more human and warm. Treating patients as equals enhanced trust and provided socialization and normative experience to some individuals impaired in that regard. Susan recalls:

> I was pregnant and the patients saw me go from just pregnant to full term and then disappearing to have this baby. And many of them, you know

watched my tummy grow and they had there own little ideas of what this baby would look like. And I mean its, for many of them it is probably the closest they have been to anybody that is in a state of pregnancy. And so after the baby was born I phoned all my clients and I said, "I am going to come to the office on such a day at such a time and I will put on a pot of coffee and if you like you are welcome to come down and see the baby, hold the baby. If you don't come or you feel uncomfortable, you don't want to come, that's fine, you are not hurting my feelings, I am just extending that opportunity to you". And many people raised their eyebrows at that but I mean why, I just think that that's, that's kind of a connectedness. I mean they saw the baby grow, now they see this actual human being. I mean those are just normal life events that the rest of us take for granted. I mean can you imagine knowing someone that had a baby and you watched them grow and then after the baby was born they said 'oh absolutely you can never see the child'. That is not normal.

As well as bringing a more personal side of herself into the relationship, Susan used this experience to socialize and normalize her clients. As she indicated, it is a 'normal' occurrence to ask about or even meet a baby if one has been following the pregnancy. Neglecting to do so can be taken as dismissive.

Many of the participants purchased coffee and cigarettes for their patients over the years. This was not expected of them, but they felt that it was acceptable practice to give a little to them every now and then. Sarah carried this further by making more substantial gifts:

> You know, if I have a chair or coffee table I am throwing out, I thought who could use this and who would appreciate this? Who would it be meaningful to? So, I would give it to them rather than donating it to the Salvation Army or some other place like that. There are certainly some people who I wouldn't do that for, but others I would.

Other participants described similar practices of distributing unused goods to clients. Dina stated that she even picks up items at garage sales for some clients, buys them wool for needlepoint and takes them flowers. If on the surface such gestures sound like over-involvement or inappropriate practice, they did contribute to the development of a meaningful, special history between nurse and client, as the participants were quick to point out. They felt that their clients appreciated the effort they took which lead to a greater degree of trust.

All such personal involvement had limits, however. All the nurses interviewed had similar points where they would 'draw the line', a phrase which describes a boundary that would not be crossed no matter what. The primary boundary unanimously recognized was not receiving phone calls at home. All participants considered phone calls after hours unacceptable and said so to each patient. When clients crossed this line, the nurses at home refused to give care personally and referred their patients to appropriate after hours resources instead. In the following visit the boundary violation would be discussed with the patient and the line which was not to be crossed would be reaffirmed.

Another line drawn was that of physical contact with clients. Responses to hugging clients varied. Most respondents felt that this was acceptable, in the right

circumstances, while others felt it was not. Those who found it acceptable to hug clients at times were very clear about the appropriate circumstances. Sarah recounted:

> I have people who have not been touched in a human sense in years. So it depends on the client, but most often times if they are coming in to the office or I am somewhere where there are other persons around that I feel are trustworthy and they say, 'please can I have a hug?', I will give them a hug. If it is a situation I am not so sure about, I will say 'oh, give me your hand' or something and then I take their hand and I will put my other hand on top of theirs and squeeze it and just tap it and that way, just so that there is that human connection.

The key to knowing whether or not to cross the line is constant assessment of individual clients, according to Sarah. She and other respondents emphasized the importance of ongoing assessment of clients and situations before crossing any lines. The lines individual nurses are willing to cross vary, however. Most stated that the caregiver's personal boundaries influenced how far they would go in a particular case, which relates to the nurse's flexibility. Rigid personalities are less likely to cross boundaries and are more likely to have inflexible barriers between themselves and their clients. It was suggested that this type of individual is not ideal for work in this specialized field.

Phase III: Crisis

As relationships between nurses and clients in this setting progress over time, crises invariably occur. Various types were described, most often involving issues of finances, family and housing and illness decompensation. What is unique about this phase of the relationship, however, is that trust has been developed and fostered and now can be

used to the client's benefit. While crises may and do develop at any time during the nurse-client relationship, the tools available to deal with them differ as the relationship grows.

Interacting.

At this phase of the nurse-client relationship interactions may change somewhat depending on the type of crisis involved. For example, for issues of finances and housing nurses may increase their input as advocates or facilitators as well as giving the clients support, though the participants in this study emphasized the importance of not encouraging increased dependence. With this in mind, they involved the clients with the issues at hand and worked together on solutions as much as possible, recognizing that severity of illness plays a part in how much input patients can have. For clients in hospital nurses would attempt to ensure that accommodations were not changed. Or, in cases of prolonged hospitalization, it might be necessary for nurses to arrange alternate accommodation or even arrange and participate in the move itself.

In situations where crises arise from clients' illnesses, it is often necessary for nurses to take on a more paternalistic role. Client protection is the key interaction at this point, particularly if there are questions of clients' competence. It is in such situations that trust in the relationship is most important. Sarah, echoed by most other participants, put it thus:

> ...they still may not believe you that those things are happening and they still may not believe that it is relevant because their insight is already starting to deteriorate, but because you have been with them through this cycle before and because you have shown that you care and respect and are committed to them,

they will kind of say, 'okay well, I don't really want to (go to hospital, take meds etc.) but if you want me to, I will'.

Dina has had similar experiences with her clients. She states that:

If their illness is too far advanced when you see them again, there is really nothing that you can do except that their trust level in you is still there so I think you can get them to do more things and maybe get them to come to hospital and get them to see somebody easier than if you didn't have this relationship.

Impacting.

The impact that nurses have on their clients may well be most profound during times of crisis. Prior to their involvement, many clients will have gone through life with frequent disruptions due to illness and thus have no lasting sense of home. Now nurses acting as advocates can help with accommodations or make arrangements for appropriate housing during crises. Each participant related that during crises involving exacerbations of their clients' illnesses, hospitalizations could be arranged much earlier and consequently were generally shorter in length. This outcome has many benefits to patients: they are less likely to lose touch with others in their communities, are often able to keep their accommodations, and generally seemed much happier with shorter hospitalizations.

Going Beyond.

During the crisis phase of the relationship the boundaries appear to loosen or become more rigid, depending on clients and their needs. While two participants felt that the boundaries needed to be tighter during crises involving illness in order to enhance nurses' control, others felt that they could be either tighter or more flexible. All participants agreed that the type of illness played a part. For example, Sarah noted that

with someone who is hypomanic, her boundaries would tighten up rather than loosen as they start to get sick:

> I think boundaries are fluid because it goes back to the cycle of the illness. If you have a male patient who is becoming hypomanic, you know they may be a perfect gentleman, but I mean part of the hypomanic syndrome is often the hypersexuality. So I probably am not going to invite him into my car or go somewhere , ah, I mean I am going to be more cautious during that period time. Yah, my boundaries will change with him. When he is back to the point where he is stable, and he is rational and those sorts of things then we can go back, so the boundaries are fluid.

The participants often described a need to tighten up the boundaries with clients exhibiting manic and disorganized behaviour or whose judgment was impaired to a degree that they even felt that their own safety was an issue. As Sarah suggested, not visiting the client alone nor taking them in the car were boundaries that became firm at this point.

Conversely, several participants described situations where patients refused medications, doctor's visits, blood tests or even leaving the house. In situations where clients were beginning to become more delusional or losing previously reasonable judgment, loosening the boundaries was seen as a way to gain bargaining power with them. Kim illustrated such a situation:

> When you are bargaining with someone to take their pills and God is telling them no they shouldn't do this, you are going to have to back off a little bit and look for another avenue, another window. Even the business of keeping doctor's

appointments, you may have to negotiate that. You may have to build in a reward, such as coffee or lunch.

Core Variable: Trust

Trust is the core variable in the process of therapeutic negotiation. All the phases lead up to or from it. Trust appears to be the ultimate goal and the ultimate tool in the relationship between nurses and clients in the community mental health setting. What makes it so important in this population is the inherent sense of distrust, paranoia and shame which often accompanies severe chronic mental illness. Some clients have never had trusting relationships in their lives, so trust takes a great deal of time to build. The changing of boundaries, loosening and tightening them as necessary, plays a major role in the development of trust for these people. The idea that someone would 'go beyond', would care enough to take time with them, to bring them gifts, to buy them coffee, to share parts of their lives, is an important building block in the construction of trust within the relationship. Lynn sums up the importance of trust succinctly in this way:

> Often all you have with your client is the relationship. That is the only tool. If you don't have trust in that relationship, then you have very little to work with. If a client trusts me, then we can work together and make a difference to his or her life. The fact that they will take a treatment or follow a direction because I ask them to, not because they think it is right, I think is a testament to the importance of trust.

There are many factors which influence this core variable, trust. The length and depth of the relationship is one. It seems more likely that trust will be stronger if a relationship has stood the test of time and weathered ups and downs. As

mentioned throughout this chapter, the trust within this relationship must be built over time. It does not spring up overnight. Clients must perceive their nurses as trustworthy. Connections must develop between caregivers and clients. Other influential factors are clients' histories and illnesses. Some clients may have difficulty trusting due to a history of betrayed trust or a lack of experience with it. Clients' symptoms influence the development of trust as well. With clients who are paranoid, disorganized or thought disordered it may be much more difficult for trust to develop. These factors are some of many influences, both internal and external, which impact how and when trust develops within the caregiving relationship.

Storyline

The following story presents a composite picture of the nurses who participated in this study.

My name is Pat Simmons. I am a nurse and have worked in community mental health for the past 5 years. Prior to this I worked in a psychiatric inpatient unit for 8 years. I originally trained in a psychiatric nursing program and then went on to complete my RN and BSN.

I feel that I have a fairly high level of expertise in the area of community mental health nursing. This is an area where you have to have excellent assessment skills and a strong knowledge base. As well, I have always worked well independently which is key when working in this setting. The patients I work with tend to be extremely ill. None of my clients are capable of working and only about half of them live independently. Many of them have frequent exacerbations of symptoms and hospitalizations do occur now and then. I feel that since I started working with my caseload of patients, the hospitalizations

have been lessened in number and are shorter in duration. It makes me feel great to know I make a difference.

Let me describe how my relationship with a patient begins and evolves. I am going to use my patient Warren as an example: he is a 46 year old man with chronic schizophrenia who has been hospitalized for months and months at a time over the years. His delusions and hallucinations are near constant in frequency and because of this he is reclusive and isolated from other individuals. When I first met Warren he was quiet and uncommunicative. I didn't have a sense early on of just how complex and frequent his hallucinations were. In the beginning I would go to Warren's house once and week and we would just have coffee together and discuss the weather or baseball or their day to day topics. The relationship at this point was quite formal and I made sure my presence was as amenable and unobtrusive as possible.

As the months went by, Warren began to discuss his delusions with me. They were incredibly complex and occasionally involved me. During this time Warren would have short lucid moments while I visited where we could discuss issues of grocery shopping etc. He admitted to disliking leaving his home as he never knew when the people in his hallucinations and delusions would appear and he was afraid of scaring others. He coped well with this by shopping at an all night grocery when there were fewer people around. At this point, about a year into our relationship, I began to loosen up the boundaries in my relationship with Warren. When I dug the potatoes or carrots from my garden, I would take extras to him and he really seemed to appreciate it. Because he had so little socialization I would make the effort to take him out for lunch or coffee when he would make it to the clinic for his doctor's appointment. About every six months or so I

would bring him a pound of coffee. I would do so not only because I drank his coffee when I visited but also because I know that coffee is important to Warren, and being on a limited budget made it impossible for him to buy anything but the cheapest brands. I felt it was a bit of a treat for him.

I knew that decompensation was inevitable in a patient as sick as Warren. Eventually the time came when I visited and his delusions were more florid and the lucid moments became nonexistent. Experience has shown me that the quicker I could get him settled, the shorter the disruption would be. I made arrangements to take him to see his psychiatrist. This was no easy task as his paranoia had increased a great deal. I was able to convince him to go with me by sitting down with him and reviewing our relationship. I said things like, "Warren, have I ever done anything to hurt you?" He would answer no. He agreed to come with me. The psychiatrist determined that hospitalization was imperative in order to make some controlled medication changes. Warren was initially opposed to this and felt threatened by the doctor and myself. When I took Warren home we spoke again of our relationship, how we had worked well together over the year and how I cared about him and his well-being. Warren conceded and agreed to the hospitalization. He did say, " I don't think I need to go but if you think I do then I will." It was at that point that I realized that the most important factor in our relationship was the trust that I had built with Warren in the time we had been working together. I think that the so-called 'extras' I do for Warren and some of my other patients are things that I would do for most individuals who are not my client, and I think they help to build the trust between us by emphasizing the respect I have for them as human beings.

V. Discussion

The nurse-client relationships described by the nurses in this study are all in some way linked to the core variable of trust. This concept influences all aspects of the relationship and can be seen as both a goal of the relationship and a tool used within it. The richness of the data obtained from the nurses in this study illustrates the value of the nurse-client relationship and the trust built within it in the context of community mental health nursing. The establishment, maintenance, and changing of boundaries within this relationship suggests flexibility is necessary to build trust and to create an effective therapeutic relationship. The fluidity of the boundaries is described in much of the data as a dynamic experience, almost like a dance, largely guided by ongoing assessment, patients' needs, nurses' personal boundaries, and a firm knowledge base. Each step in this dance, each maneuver made by the nurse in this potentially fragile relationship, must be and is carefully considered as to its ultimate benefit or risk.

The grounded theory developed in this study emerged from the nurses' thoughtful descriptions and discussion. These findings are echoed and confirmed in several of the few articles found addressing the concept of trust within a caregiving relationship. Those articles which appeared not to correspond with these findings often related to non-psychiatric populations of patients, each of which had uniquely different needs and attributes.

The Nurse-Patient Relationship

The nurse-patient relationship as described by the nurses in this study can be compared with that of Peplau's Interpersonal Theory of Nursing (Peplau, 1952), which describes three phases in the nurse-patient relationship: orientation, working, and termination. The first phase is congruent with phase I of the process described in this study, 'establishing the relationship'. In Peplau's theory, this initial phase is characterized by the establishment of parameters within the relationship and the initial development of trust. Similarly, the nurses of this study suggested that roles and expectations are explored and trust is beginning to be established at this point.

Thorne and Robinson (1988) studied trust within the health care relationship and concluded that patients entered into health care relationships with an almost blind trust in their caregivers. The findings contained herein do not support this claim, however. In the chronically mentally ill population, building trust in the relationship can be an arduous task. The incongruence between these studies may be attributed to the uniqueness and special needs of the chronically mentally ill population. The nurses in this study were adamant about the importance of understanding the isolation and distrust many of their clients feel. Isolation and abandonment in their pasts as well as ongoing symptoms often has closed them off to others, making the establishment of a trusting relationship a true challenge.

In the second phase, the working phase per Peplau, the problems facing the client are identified and the nurse works with the client to resolve them. Here, as illustrated in this study, the relationship itself is seen to be evolving, and a process called therapeutic

negotiation occurs. During this phase, the nurses and clients work together to negotiate issues and trust is fostered through ongoing interaction, respect and caring.

Peplau's third and final phase, resolution, involves the termination of the relationship. The data from this study depart from Peplau's theory at this point. According to the nurses interviewed, the third phase, crisis, involves the utilization of the developed trust within the relationship. Here trust may be used to influence care and treatment with a patient who, due to illness decompensation or other psychosocial crises, may be otherwise reluctant to comply. The primary difference in Peplau's third phase and that of this study is again related to the latter's unique setting. Relationships in community mental health nursing generally carry on indefinitely, with termination of the relationship occurring with the departure of the nurse, the death of the nurse or patient, or with a change in caregiver for reasons deemed to be best for the client.

Descriptions of the nurse-patient relationship given by the nurses in this community mental health setting fit with those which Yuen (1986) describes in a discourse on the nurse-patient relationship within the psychiatric environment. Yuen found that a reevaluation of relationship within the profession of nursing has accompanied the advent of community therapy. It is noted that in this unique setting, relationships between the nurse and patient are more personal, requiring a greater degree of sharing of personal feelings and expressions. Yuen's findings are consistent with those of this study, which suggest that a greater degree of interaction between nurse and client renders the relationship itself a powerful tool in dealing with the challenges of clients' lives and illnesses.

Trust Within the Nurse-Patient Relationship

According to Webster's New World Dictionary, trust as a noun is defined as a "firm belief in the honesty, reliability, etc. of another" (1990, p.633). As a verb, the dictionary defines it as 'to believe' or 'to hope' but also as encompassing the concept of committing something to one's care. In the context of this study, clients are ultimately committing themselves to nurses' care and nurses are committing themselves to care for their clients.

Johns (1996) concept analysis of trust identifies trust as an important component of the nurse-patient relationship and a major factor in treatment compliance. As indicated in this study, trust has been explicated as both a process and an outcome within the context of the nurse-patient relationship (Thorne & Robinson, 1988; Johns, 1996). Johns developed a process/outcome model of trust as a core concept and identifies four stages associated with it. The first, assimilation of information, involves assessment of the situation or person to be trusted, accounting for risk, competence and reliability. The second entails decision-making with decisions based on the individual's perceptions of trustworthiness. The third is the trust relationship, the crucial stage of entering into the trust relationship both as a process, which is dynamic and an outcome, also static and time-specific. Finally, the fourth phase, consequences of trusting, involves evaluation of the results.

Johns' model explores trust as a core concept from the point of view of those doing the trusting, who according to Johns are willing to enter relationships which in some way create or increase their vulnerability. This study explored the core concept of trust from the perspective of those offering themselves to be trusted, nurses attempting to

secure the trust of their clients. From this point of view, those attempting to gain trust from clients benefit greatly from understanding how trust is developed and utilized both as a process and an outcome.

Throughout this study trust has been identified as the key to an effective relationship which ultimately leads to patient wellness. According to Morse, Calsyn, Miller, Rosenberg, West & Gilliland (1996), in their description of an outreach model to homeless mentally ill people, the most critical point in providing effective care is the development and maintenance of a trusting relationship between the outreach worker and client. In congruence with this study, the authors' maintain that a trusting relationship is necessary to gain client compliance as well as providing a therapeutic tool to assist clients in developing positive coping skills and a generally healthier aspect. A further consistency between the study done by Morse et al. and this study is the observation that trust must be developed and can be done so by providing practical services to the client. They describe an instance where a psychiatrist took on the role of bingo game operator in order to engage clients' trust, behaviour which could be viewed as at least unorthodox, in not "going beyond". The authors themselves describe the activities often undertaken to establish a relationship with clients as 'non-traditional in nature'.

Further suggested in the Morse et al. study is the need for the balancing of flexibility and limit-setting within the nurse-patient relationship. The authors acknowledge the need for limits within the relationship both to prevent staff overwork and as a means for client growth through autonomous coping. In this study, nurses described limits as being those lines which are not to be crossed and identified after-hours contact and intimate contact with their clients as two of these. Flexibility was seen as necessary within

this relationship regarding various aspects of services provided to clients, a flexibility which may include unorthodox nursing practices such as those described in this study.

An interesting study by Repper, Ford and Cooke (1994) explores how trust is built in relationships between case managers and their clients who experience severe, chronic mental health problems. The purpose of Repper et al's study was to "identify, describe and provide an understanding of case managers' relationships and interventions with and for their clients" (1994, p.1098). Consistent with the findings of this study is the notion that the relationship between case managers and clients is central to the former's work. The findings of Repper et al's study identified principles regarding such work. One is the use of realism as a strategy to avoid or overcome client frustration. Keeping a long-term perspective was identified as being of great importance in building and maintaining a trusting relationship with clients. Flexibility was noted as necessary to offering services based on individual needs. The responses in Repper et al's study correlated with this study regarding rule (boundary) flexibility: "Since it was the system that had failed to be acceptable to many clients, case managers felt that the opportunity to move away from these rules was important; flexibility facilitated provision of a service on the client's terms" (p. 1100).

Repper et al. noted that trust was seen as enhancing client-case manager relationships to the point where clients felt confident in confiding in their case managers. The case managers in Repper et al's study noted that, during engagement of clients, being able to demonstrate their usefulness through dealing with practical problems helped to build trust in the relationships. Finally, Repper et al's study concurs with this study in the description of the role of client-caregiver relationships in relation to treatment compliance.

Their clients viewed case-managers as supports and monitors but because of the sound, trusting relationship did not perceive case-managers as daunting authority figures, and they denied feeling coerced into accepting treatment.

Boundary Theory

Much of the literature relating to boundaries focuses on boundary violations of a fairly obvious nature, including sexual misconduct. This study did not enter into the realm of such violations, but rather focused on the gray zones, on boundary crossing where the best course of action is not always obvious (Alberta Association of Registered Nurses, 1996). This definition of gray zones explains what was described by the subjects of this study. From an observers perspective, the course of action undertaken by the community mental health caregiver may appear to be worrisome or at least questionable. The practitioners in this study were able to justify their practices, however, universally describing their actions as ultimately meeting their clients' needs. What makes these particular situations even more nebulous is the fact that the needs being met may not be readily identifiable. Much of the time the benefits to the client accrue at a much later date through utilization of the trust that has been built.

According to Guthiel and Gabbard (1993), clinicians generally feel they have an intrinsic understanding of boundaries, a notion nurses in this study seem to support. They were able to describe boundaries they would not cross and those they would, including how and when to loosen boundaries, something inherently known through experience and patient assessment. Although rationale for such was forthcoming and concise, it was based not on any theoretical or procedural foundation, but rather on nurses' knowledge, assessment and self-awareness. Backlar (1996) supports Gutheil and Gabbard's position

on this, stating that dealing with boundaries in one's own practice is no easy task and acknowledging that professional codes of ethics may not be aligned with practices of one's colleagues in mental health professions. Backlar suggests that boundary issues are inherently difficult partly due to the changes and variation in today's delivery of mental health services. The nurses in this study felt that the multiple settings and roles of the caregiver make the structured boundaries which govern traditional, institution-based practice somewhat unworkable in community mental health care.

Backlar further acknowledges that the traditional view of the nurses role and the boundaries which accompany it have been sabotaged by community mental health programs which include home visits, meeting the clients for coffee, assistance with grocery shopping, offers of food and clothing, etc., in order to gain trust. She also recognizes the inherent difficulty facing this type of practitioner, noting that the caregiver must identify and address the needs of the client, attempt to gain trust, and above all never take advantage of that trust. She warns that although we can learn the rules about roles and relationships, effective use of them requires personal judgment which cannot be reduced to a standard procedure. This view was firmly voiced by the nurses in this study, who felt that their practice was founded on assessment, judgment and reasoning rather than firm rules.

While giving nurse's in this setting more autonomy regarding the type of care they give may seem ideal, it must be noted that serious boundary violations often emerge following practice in 'gray areas'. According to Gallop (1998) boundary violations often begin with something such as excessive self-disclosure. Furthermore, caregivers may attempt to 'rescue' their clients and in doing so may violate boundaries, which can be

harmful instead. Entering into a dual role as therapist and friend can be extremely harmful to both parties and nurses must monitor their behaviour constantly for such indiscretions (Gallop, 1998). The nurses in this study, given the type of relationships they often develop with their clients, are at risk of crossing this line. They were aware of this as well as the potential consequences of such behaviour and each alluded to the need for vigilance and awareness regarding potential boundary crossings which are not to the clients' benefit.

Several nurses in this study noted that they had dealt with situations in which their clients developed sexual or loving feelings towards them. Peternelj-Taylor (1998) in her study regarding nurse-patient relationships with forensic psychiatric patients suggests that this phenomenon can arise when nurses conducts themselves in a social manner rather than a professional one. The nurses in this study dealt with such situations in ways corresponding with Peternelj-Taylor's suggested responses when patients attempt to sexualize relationships, by taking time with clients and reinforcing the purpose of the relationship, setting limits on particular behaviours and clarifying their own nonsexual feelings. According to Peternelj-Taylor, this straightforward approach is most appropriate as it decreases the chances of developing ambiguity and confusion about the relationship.

Implications for Nursing

This study has implications for nurses, administrators and educators alike. The practice which nurses in this unique setting undertake often bends the rules or goes beyond what is conventionally acceptable. Understanding of reasoning behind this practice, however, gives the power to make change. All nurses in this study were able to articulate their practice rationale. All noted that the chronically mentally ill population in

the community had unique needs which didn't always correspond with traditional nursing care.

Continuing exploration of this area of practice can bring unorthodox but worthwhile ways of caring into the forefront of nursing knowledge. Students and practicing nurses can be taught the importance of being creative caregivers and of the need for building a trusting relationship with their clients. The practices which the nurses in this study described are not to be undertaken lightly or by novice practitioners, but experience and role modeling can lead them toward the level of creativity and commitment that these nurses represent. Administrators can develop guidelines or policies which encompass going beyond without being punitive.

There are no doubt unlawful and unethical practices which nurses have undertaken in going beyond. In this study, however, the practices discussed, although unorthodox, were based on sound judgment and reasoning, attributes which need to be employed for each individual client. It also needs to be understood that these expert practitioners value their autonomy and ability to affect positive change in their client's lives. Perhaps it is time that nursing as a profession develops a greater understanding of the unique needs of clients in various settings, while maintaining sound rules regarding unethical and unlawful practice.

Professional associations have deemed many of the ways in which the nurses in this study practice as being in the gray area (AARN, 1996). These nurses and many others admit to practicing within this gray area at times, however, and this does not particularly concern them. While the value of having firm boundaries in regard to patient safety formulated by professional associations cannot be underestimated, this study reveals that

many boundary crossings are soundly reasoned and unequivocally based on patients' needs and best interests.

Suggestions for Further Research

This study is informative for those working within the community mental health field and thought-provoking to those in other disciplines. It has generated for the author many ideas for further research to be undertaken in this underdeveloped area of nursing knowledge. As nursing continues to evolve into a more humanistic profession, further study into the intricacies of the nurse-client relationship are necessary. Boundary issues are coming to the forefront of nursing practice at this point in time and further question of the ethical issues surrounding boundaries would help. The concept of trust requires further exploration within the nursing profession. A similar study from the clients' point of view would expand perspectives. Most importantly, it would be interesting to focus in the future on more precise details of how decisions to go beyond are made, on assessment of benefit and risk. The more research generated regarding the nurse-client relationship and the process of changing boundaries within it the better. This research can give nurses what they need to become more autonomous and more respected in the judgments they make within their practice.

The realm of relationship boundaries is not unique to nursing. Research from other disciplines regarding boundaries and trust in relationships with an unequal balance of power would further increase our knowledge on these issues.

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Appendix A

Interviewing Guide

These questions were a guide for the researcher and may not have been asked of all participants. As well, they were not necessarily used in this order:

1. How do you define professional boundaries with clients within your own practice?
2. Tell me about your experiences in establishing professional boundaries in your relationships with clients.
3. Tell me about your experiences in going beyond what is considered 'acceptable' boundaries.
4. Tell me about the clients with whom you are more likely to stretch your boundaries.
5. What is the impetus which leads to stretching your professional boundaries?
6. What are the results of engaging in relationships beyond the realm of the 'gray zone' in relation to professional boundaries?
7. What are the reactions of your peers regarding the way you give nursing care?
8. What are the reactions of your clients regarding the way you give nursing care?
9. How do you differentiate between personal and professional boundaries?

Appendix B

Information Sheet

Boundary Issues in

Community Mental Health Nursing

I am a Master of Nursing student at the University of Alberta and am exploring the area of boundary issues between nurses and clients in the community mental health setting. I am interested in researching the process which mental health nurses go through in establishing, maintaining and extending professional boundaries in the relationships they have with their clients. I would be interested in hearing your experiences. Being involved in the study requires up to three hours of your time. If you would like more information please contact Terri Lidstone at 438-1102.

Appendix C

Consent Form

Title of Research:

Boundaries and Trust in Community Mental Health Nursing

Researcher:

Terri Lidstone RN, BScN, MN Student
University of Alberta
Faculty of Nursing

Purpose of the Study

The purpose of this study is to identify, describe and analyze theoretically the process of establishing, maintaining and extending professional boundaries in the relationships between community mental health nurses and their clients. Factors impacting boundaries will also be examined.

Procedures and Confidentiality

This study will involve interviews with the researcher which will focus on your experiences, thoughts and feelings surrounding boundary issues. There will be up to three interviews of approximately one hour in length and will occur at a time and place which is convenient to you. These interviews will be tape recorded and then will be typed. All information identifying you will be erased from the tape following this. Your name will be replaced by a code number and a pseudonym will be used in any reports, articles or talks relating to this study. Only the researcher will know the code. All identifying information such as your name, address, and phone number will be kept in a locked cabinet separate from the rest of the information and will be destroyed after the study. Anyone working with the researcher on this study (i.e.: transcriptionist, research assistant), will be asked to sign an oath of confidentiality. If the information is to be used for future studies, approval will be sought from an ethics committee at another time.

Quotations will be used in reports of the study. The quotations will not identify the speaker by name. It is possible however, that someone familiar with the setting might recognize the source of the quotation.

Voluntary Participation

You do not have to participate in this study if you do not want to. You may withdraw from the study at any time simply by letting the researcher know. You may also refuse to answer any questions.

Risks

There are no known risks in participating in this study. However, if you divulge information about illegal activities to the researcher, she will be obliged by law to notify the appropriate person or agency. Although you will not benefit directly from this study, it is hoped that nursing interventions and standards of practice may change based on the findings from this research.

If you have any concerns or questions, please contact the researcher at any time

Terri Lidstone
438-1102

Consent

I, _____ have read this information and agree to be in this study called Professional Boundaries in Community Mental Health Nursing. I have had the opportunity to discuss the study with the researcher and am satisfied that my questions have been answered. I have received a copy of the consent form.

_____ _____

Researcher Date

Appendix D

Research Personnel

Principal Investigator: **Terri L. Lidstone, RN, BSN**

The principal investigator in this study will be responsible for:

-selection and interviewing of research participants
-all sampling, data collection, analysis, coding and managing of all data
-all matters pertaining to the anonymity and confidentiality of the study
-writing of the research findings and dissemination of the research, including publication

Thesis Supervisor: **Dr. Olive Yonge**

- will assist and guide the researcher through all aspects of research

Committee Members: **Dr. Al MacKay, Dr. Brenda Cameron**